



Wyoming State Board of Pharmacy

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WyIR

By Jason Cory, PharmD Candidate

Pharmacists have a great opportunity to assist in ensuring that patients are being immunized and continue to keep current with their immunizations. While pediatric immunization programs in the United States have been successful, the immunization rate of younger adults has remained unacceptably low. As pharmacists, we can help to improve the rate of immunization in young adults by either giving immunizations or by educating patients on the importance of immunizations. Some diseases are becoming very rare in the US, such as polio and diphtheria, however, it is still important that we continue to vaccinate against these and other diseases so that they do not make a comeback.

Another important factor in the immunization process is record keeping. The record keeping of these vaccinations is just as important as the actual vaccination itself. Keeping good records allows for information to be gathered on the number of people that are receiving immunizations, and it is also very important for a patient to have records so he or she knows what he or she has received. This record keeping can be completed by using the Wyoming Immunization Registry (WyIR) system and is now required by law (Wyoming Statute §33-24-157) in the state of Wyoming for pharmacists that are administering vaccines to adults and children.

The WyIR is a secure immunization database that contains the vaccination records of Wyoming residents. The Wyoming Immunization Unit of the Wyoming Department of Health maintains the WyIR system. It is available to authorized users free of charge and can be accessed 24 hours a day, seven days a week. The WyIR system not only provides an electronic record of patients' vaccinations, but also has the ability to assist providers with the management of their vaccine inventory. Soon, automated vaccine ordering will be integrated into the system. WyIR also has the capability to aid providers in possibly increasing vaccination rates by generating reminder notifications to alert patients when their immunizations are due or needed. Along with the reminder notification, it also can send out notifications in the event that a vaccine is recalled.

The only equipment that is required to use the WyIR system is a computer and Internet access. However, there is also an option of having a barcode scanner that would speed up patient check-in by scanning the barcode on the back of the patient's driver's license and automatically completing the patient's general information.

In order to assist caregivers in utilizing the WyIR system to its full potential, there is a training session that can be completed during an on-site visit or on the computer with desktop sharing. The Wyoming Immunization Unit of the Wyoming Department of Health is more than happy to assist in easing the process of getting started using the WyIR system. To become an authorized user simply call the WyIR help-desk

at 800/599-9754 or contact the project coordinator, John Anderson, at 307/777-5773. The WyIR Web site is <https://wyir.health.wyo.gov>.

Prevention Management Organization Partners With Wyoming Medical Center on Project to Promote Drop Boxes Using Prescription Labels

By Jana Gurkin, Community Prevention Professional, PMO of Wyoming

The Prevention Management Organization (PMO) of Wyoming has partnered with the Wyoming Medical Center (WMC) to help raise awareness of prescription drug abuse, proper disposal of unused medications, and the location of the Casper, WY, medication drop box by using prescription labels.

The Natrona County PMO team has been working on a year-long prescription drug abuse awareness and media campaign for Natrona County. The team decided that having a small circular label or sticker on newly filled prescriptions might be a way to help encourage individuals to use the drop box at the Casper Police Department for any unused medication. Collaboration followed between the PMO and Patti Nelson, pharmacist at the WMC pharmacy.

A sticker was designed to be placed on the lid of prescription bottles filled at WMC for hospital staff and volunteers. The sticker message reads "Dispose of Unused Drugs" on the outer edge, and "24/7 Medication Drop Box: Hall of Justice 201 N. David St." in the center of the sticker on a bright green background. A batch of 5,000 stickers was printed by a local printing company for a three-month pilot program at the WMC pharmacy. Each prescription filled at the pharmacy over the three-month period will have a sticker placed on the lid of the bottle in hopes that the patient will find it highly visible.

The pilot sticker program comes at a time when an increasing number of medication drop boxes are becoming available to communities across the state. Having more drop boxes available is an idea welcomed by many who are concerned about prescription drug abuse. "My hope has always been that we'd have enough drop boxes across the state so that everyone would have access to it," said Nelson.

The three-month sticker pilot program should finish in early December. The PMO will look into the amount of medication turned in over the course of the program and increased levels of awareness about the drop box, as well as look for a potential increase in volume of medication turned in over the following months.

The partnership between the PMO and WMC simply made sense. Nelson is the pharmacist in charge of the documentation and disposal process of drugs turned in to the Casper Police Department drop box. Every four to six weeks she goes through the process of separating and documenting the items dropped off. Nelson sets aside any packaged medications that can be donated to the Wyoming Medication

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Enteric-Coated Aspirin Recalled for Potential Acetaminophen Mix-Up

In June 2013, Advance Pharmaceutical Inc initiated a voluntary recall of Rugby Laboratories label enteric-coated aspirin tablets, 81 mg (Lot 13A026; expiration date: January 2015) due to a complaint that a bottle labeled with this product name actually contained acetaminophen 500 mg tablets. This over-the-counter (OTC) product is packaged in bottles of 120 tablets with National Drug Code 0536-3086-41 and Universal Product Code 3 0536-3086-41 9. The affected lot was distributed nationwide by Rugby Laboratories to wholesalers and retailers. The manufacturer warns that inadvertently taking acetaminophen, 500 mg, instead of enteric coated aspirin, 81 mg, according to the directions on the label, can lead to an acetaminophen overdose and potential severe liver damage. The manufacturer indicates that consumers who take the dosage as indicated on the defective product labeling may be ingesting up to 24,000 mg of acetaminophen, which is about six times the maximum recommended daily dose of acetaminophen (4,000 mg).

Consumers who have bottles from the affected lot should stop using the product and return it to the pharmacy or store where it was purchased and should contact a health care provider if they are experiencing any problems that may be related to using the product. Food and Drug Administration (FDA) notes that any adverse reactions related to the use of the product should be reported to FDA's MedWatch Program. More information about this recall is available on the FDA Web site at www.fda.gov/Safety/Recalls/ucm357909.

Barcoding Technology for Community Pharmacy

ISMP
INSTITUTE FOR SAFE MEDICATION PRACTICES

This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency that analyzes medication errors, near misses, and potentially hazardous conditions as reported by pharmacists and other practitioners. ISMP then makes appropriate contacts with companies and regulators, gathers expert opinion about prevention measures, and publishes its recommendations. To read about the risk reduction strategies that you can put into practice today, subscribe to ISMP Medication Safety Alert!® Community/Ambulatory Care Edition by visiting www.ismp.org. ISMP is a federally certified patient safety organization, providing legal protection and confidentiality for submitted patient safety data and error reports. ISMP is also an FDA MedWatch partner. Call 1-800/FAIL-SAF(E) to report medication errors to the ISMP Medication Errors Reporting Program or report online at www.ismp.org. ISMP address: 200 Lakeside Dr, Suite 200, Horsham, PA 19044. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.

Barcoding technology is well-established in industries outside of the health care sector and is now being used within health care to enhance efficiency and safety, and in pharmaceutical wholesale operations to improve supply chain inventory and efficiency. Numerous studies prove the effectiveness and cost benefits of using barcoding technology during the drug dispensing process. About 75% of wrong drug or wrong dose errors are captured and corrected using barcode technology¹ and there is sufficient evidence that barcode scanning is becoming the standard of practice in pharmacies.

Although barcoding technology is mature with abundant evidence regarding its effectiveness, a 2006² study showed that only half (53.5%) of United States community pharmacies utilize a barcode scanner for verification/identification of medications. The study also

revealed significantly lower adoption in independent pharmacies (11.5%) compared to chain pharmacies (62.6%).

According to a survey conducted by ISMP in 2009, the most frequently reported reasons for implementing barcode scanning for product verification included a desire to improve the accuracy and safety of the dispensing process, the ease with which the technology fits with pharmacy workflow, improvement of staff efficiency and inventory control, and a belief that the technology was necessary to stay in business. The most common reasons for **not** implementing barcode scanning for product verification, other than cost, included uncertainty regarding the "right" vendor product, satisfaction with the current system (without barcode product verification), and perceptions that the technology would reduce staff efficiency.

ISMP has developed a tool, Assessing Barcode Verification System Readiness in Community Pharmacies, to help address the reasons why barcode scanning has not been implemented and to facilitate the adoption of this technology in an estimated 27,327 community pharmacies that do not currently utilize it for product verification.

Given the resource commitment to purchase barcoding systems and the potential for technology to have a profound effect upon the work environment, this tool will help community pharmacy managers and owners better understand the issues related to barcode product verification systems. It will also help managers assess the pharmacy's readiness for the technology, prepare for the selection of a system, and implement the technology effectively.

Barcode scanning to verify prescription products prior to dispensing improves the safety and quality of pharmacy care provided to patients and increases efficiency during the provision of pharmacy services. Although technology should not be seen as a panacea, it can be a useful tool when used appropriately and combined with other patient safety strategies.³ Does your pharmacy use barcode technology for product verification? If not, please access this free tool, at www.ismp.org/AHRQ/Default.asp?link=sa.

¹Cochran GL, Jones KJ, Brockman J, Skinner A, et al. "Errors prevented by and associated with barcode medication systems." *Joint Comm J Qual Pt Safety*. 2007;33(5):293-301.

Ukens C. "New study sheds light on medication errors." *Drug Topics*. 2002;146(21):33.

²Skrepnek GH, Armstrong EP, Malone DC, Abarca J, et al. "Workload and availability of technology in metropolitan community pharmacies." *J Amer Pharm Assoc*. 2006; 46(2):154-160.

³American Hospital Association, Health Research and Educational Trust, Institute for Safe Medication Practices. "Pathways for medication safety: assessing bedside bar-coding readiness." 2002. Accessed on October 15, 2010 at: www.ismp.org/selfassessments/PathwaySection3.pdf.

ISMP Launches Medication Safety Alert! Newsletter Tailored for LTCFs

ISMP has launched a new *ISMP Medication Safety Alert!* publication, *Long-Term Care Advise-ERR*, as a means to provide medication error prevention information tailored to assist staff and providers in long-term care facilities (LTCFs).

With *ISMP Medication Safety Alert!* publications making a significant impact on preventing medication errors, ISMP is now providing this new resource tailored to LTCFs. ISMP notes that medication errors reported to ISMP Medication Errors Reporting Program include reports from LTCFs. More information and a link to subscribe to this new publication are available in the Newsletters section of the ISMP Web site at www.ismp.org/newsletters/longtermcare.



Compliance News to a particular state or jurisdiction should not be assumed. Please consult the law of such state or jurisdiction.)

FDA Warns of Rare Skin Reactions in Patients Taking Acetaminophen

FDA has issued a consumer update that warns of rare but serious skin reactions that may occur in patients taking acetaminophen. These complications include three serious skin reactions: Stevens-Johnson Syndrome (SJS), toxic epidermal necrolysis (TEN), and acute generalized exanthematous pustulosis (AGEP). SJS and TEN can both be fatal, and usually require hospitalization. Patients suffering from AGEP commonly recover within a few weeks after they stop taking the medication that caused the reaction.

Symptoms of these conditions include skin rashes, blisters, and widespread damage to the surface of the skin. Patients taking acetaminophen or other compounds that contain acetaminophen should be advised to stop taking the medication if they experience such symptoms and should consult their health care providers or seek an emergency department immediately.

FDA emphasizes that this information should be viewed within the context of millions of patients who, over generations, have used and benefited from acetaminophen and stresses that severe allergic skin reactions are an extremely rare condition. Further, the agency notes that many medications can cause allergic reactions, and skin allergy warnings have already been added to the drug labels of other categories of OTC analgesics including ibuprofen and naproxen. "This new information is not intended to worry consumers or health care professionals, nor is it meant to encourage them to use other medications," said Sharon Hertz, MD, deputy director of FDA's Division of Anesthesia, Analgesia, and Addiction Products. "However, it is extremely important that people recognize and react quickly to the initial symptoms of these rare but serious side effects, which are potentially fatal." The full consumer update is available on the FDA Web site at www.fda.gov/ForConsumers/ConsumerUpdates/ucm363010.htm.

Reminder to Purchase Drugs Only from Licensed Wholesalers, Including VAWD-Accredited Wholesale Distributors

To ensure that patients are receiving safe, FDA-approved medications, pharmacists and other health care providers should purchase prescription drugs either directly from the manufacturer or from wholesale drug distributors licensed in the US as advised by FDA. The agency provides a list of state agencies for assistance in verifying licensure at www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/ucm281446.htm.

Another way that pharmacies can be assured of the legitimacy of a wholesale distributor is to look for the National Association of Boards of Pharmacy® (NABP®) Verified-Accredited Wholesale Distributors® (VAWD®) Seal. Those wholesale distributors that achieve VAWD accreditation are in compliance with state and federal laws and NABP's VAWD criteria. NABP has recently revised the VAWD criteria to allow virtual manufacturers and virtual wholesale distributors – a growing segment of the pharmaceutical wholesale industry – to qualify for VAWD, as well as to implement other changes aimed to help to ensure that the drug supply chain remains secure.

The revised VAWD criteria responds to changing business models and helps safeguard drugs in distribution at a time when there is an increased risk of counterfeit and substandard drugs entering the legitimate US drug supply chain. In particular, the criteria have been revised

to provide stronger assurance that drugs diverted from pharmacies and unlawful sources are prevented from entering into the supply chain.

For a listing of VAWD-accredited facilities, please visit www.nabp.net/programs/accreditation/vawd.

Voluntary Recall of Unexpired Sterile Products After Reports of Adverse Events

FDA has announced a voluntary recall of all lots of unexpired sterile products produced by Specialty Compounding, LLC, in Cedar Park, TX. FDA received reports of 15 adverse events at two hospitals (Corpus Christi Medical Center Doctors Regional and Corpus Christi Medical Center Bay Area) potentially related to the use of these sterile products. Affected patients received an intravenous infusion of calcium gluconate supplied by the company.

Patients who were administered the injectable drug products are at risk of life-threatening infections. The recall applies to all unexpired sterile compounded medications dispensed by the company, including all strengths and dosage forms. Recalled products were distributed directly to hospitals and physicians' offices in Texas, and to patients located nationwide (with the exception of North Carolina). No calcium gluconate was shipped outside the state of Texas. Health care providers and patients should stop using all recalled products and return them to Specialty Compounding.

Veterinarians Not Eligible for NPIs, CMS Clarifies

Centers for Medicare and Medicaid Services (CMS) has become aware of cases in which veterinarians are told, incorrectly, that they must provide a National Provider Identifier (NPI) number for prescriptions they have written to be dispensed. The agency has issued a clarification, stressing that veterinarians do not meet the regulatory definition of "health care provider," and thus may not obtain NPI numbers. The clarification also states that "Any entity that insists veterinarians obtain an NPI [is] attempting to require veterinarians to obtain NPIs fraudulently." CMS also notes that "if a veterinarian fulfills the definition of 'health care provider' in a profession other than furnishing veterinary services," such as if they are also a nurse practitioner, "the veterinarian would be eligible for an NPI but would select a Nurse Practitioner code (not a Veterinarian code) from the Healthcare Provider Taxonomy Code Set when applying for an NPI."



Pharmacists & Technicians:
Don't Miss Out on Valuable CPE Credit.
Set Up Your NABP e-Profile and Register for CPE Monitor Today!

Continuing pharmacy education (CPE) providers who are accredited by the Accreditation Council for Pharmacy Education (ACPE) have integrated CPE Monitor® into their systems and are requiring pharmacists and pharmacy technicians to provide a National Association of Boards of Pharmacy® (NABP®) e-Profile ID number and date of birth (MMDD) in order to process ACPE-accredited CPE credit.

Visit www.MyCPEmonitor.net to set up your NABP e-Profile and register for CPE Monitor and avoid possible delays in your CPE reporting.

CPE Monitor is a national collaborative service from NABP, ACPE, and ACPE providers that will allow licensees to track their completed CPE credit electronically.

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Donation Program. With the help of the Casper Police Department, narcotics and other items that require incineration are taken to WMC where its incinerator is used to properly dispose of the drugs that were turned in. The community need for this service is demonstrated by the volume of drugs regularly dropped off; in any given six weeks time, Nelson may have close to 200 pounds of drugs turned in.

As more counties statewide have medication drop boxes added to their local police departments, the need for pharmacists to help with the process of documenting items turned in and properly disposing of them is growing rapidly.

The PMO of Wyoming and the Wyoming Medication Donation Program are funded by the Wyoming Department of Health.

Recent Disciplinary Actions

Note: All fines are payable to the county treasurer where the action occurred for the credit of the public school fund in that county pursuant to Wyoming Statute §33-24-113(f).

R.M.H. Pharmacy Intern License #3920: Conditioned due to Plea Bargain Docket No. 31-590 for possession of a Schedule III controlled substance (CS).

L.L.D. Pharmacist License #3125: Letter of admonition for medication error. Required to complete five-hour continuing education (CE) on medication safety and submit a plan to prevent future errors.

A.E.P. Pharmacist License #3513: Revoked due to guilty plea of larceny by bailee, a felony, and possession of a CS, a misdemeanor.

R.D. Pharmacist License #2234: Stipulated order changing terms of the conditional license.

Counseling

The Wyoming State Board of Pharmacy continues to receive complaints and comments about the lack of counseling in Wyoming pharmacies. Wyoming Pharmacy Act, Rules and Regulations, Chapter 9, Section 5(a), states, "Upon receipt of a prescription and following a review of the patient's record, a pharmacist or a pharmacy intern shall personally offer to discuss matters which will enhance or optimize drug therapy with each patient or caregiver of the patient." Chapter 10, Section 4, states, "The pharmacist, not the pharmacy technician shall . . . (e) Make the offer to counsel. (f) Counsel." Some pharmacies have computerized signature logs that ask "do you have any questions for the pharmacist?" and some pharmacies have the clerk or technician ask the same question. The rules do not say that a computer or clerk can make the offer to counsel and they specifically say that a pharmacist or pharmacy intern **shall** make the offer to counsel. "Show and tell" before dispensing is a proven method to prevent medication errors. Training the customer to expect counseling is the right thing to do to improve compliance and prevent misuse. Counseling is also

the right thing to do to enhance a culture of safety in the pharmacy. Counseling is also the right thing to do because it is required by law.

Prescription drug abuse is a large and growing problem in Wyoming and every other state. Every Schedule II prescription is a new prescription and the law applies that the pharmacist **shall** make the offer to counsel. Using simple open-ended questions, such as "What is your pain level today? Are you having any side effects? Has your pain changed recently?" shows the customer you care and provides an opportunity to prevent problems. The pharmacist may learn information that should be relayed to the prescriber.

A pharmacy technician was observed correctly telling a patient, "The pharmacist will be off the phone in a minute and she will hand you this prescription – it is required by law." Counseling will be a focus during inspections in 2014. As well as being required by law, counseling is good professional practice, good financial practice, and a good risk management technique.

License Renewals for Pharmacists and Pharmacy Technicians

Renewal notices were sent to pharmacists and pharmacy technicians in early November 2013. All licenses expire as of midnight on December 31, 2013, at which time a late fee will be added. Pharmacists-in-charge need to be checking the licensure status of pharmacists and pharmacy technicians to ensure that no unlicensed person is performing pharmacy functions. Pharmacists should renew their preceptor and immunization registrations online at the same time they renew their licensure. No CE records are to be provided to the Board at this time. A random audit will be conducted in February 2014. Be sure to check your CPE Monitor® activity records at www.MyCPEmonitor.net by logging in with your e-Profile ID for Accreditation Council for Pharmacy Education-accredited CE completed in 2013 before completing your renewal for 2014. The Board continues to hold licensees accountable if they do not have the correct number of hours. **For 2014 renewals, pharmacy technicians will not be able to use an online process and must submit a check or money order with the paper form.**

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